CLIENT INFORMATION SHEET

The information you give us on this form is very important. It will help us investigate your animal encounter and determine how to best proceed with your case. If you don't have all the information we ask for in this form, please let us know so we can help you get it. **All of your answers will be kept strictly confidential.**

Today's date: _____

How were you referred to **The Law Offices of Dianne L. Sawaya, LLC**?

_____

PERSONAL INFORMATION

Name: _____

Date of birth: _____ Social Security No._____

Address: _____ Apt.: _____

City: _____ State: _____ ZIP : _____

Telephone no.: (Home) _____ (Work) _____

(Cell) _____

May we have permission to communicate via text message with you? Yes____ No____

Do you have a ***Facebook*** page? Yes ___ No ___ **(Please review the handout on the Dos & Don'ts of social networking)** E-mail: _____

Would you like our *electronic client newsletter* sent to your email address? Yes ____ No_____

Height: _____ Weight: _____ Are you: Right-handed ____ Left-handed: ____

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's name: _____ Spouse's phone no.: _____

Dependents and ages: _____

_____

Your driver's license: No. _____ Exp. date: _____

****IMPORTANT INFORMATION****

Please list the name of a relative or friend who does not live with you: (for contact in an emergency and we can't reach you)

Name: _____ Phone no.: _____

INFORMATION ABOUT THE INCIDENT

When did the incident happen? Date: _____ Time: _____

Where did the incident happen? _____

What type/breed of animal was it? _____

Please briefly describe what happened: _____

_____

_____

Did you fall? Yes ___ No ___ Were you injured when you fell? Yes ___ No ___

Please describe any bruises, cuts or other visible injuries that were caused by the animal's attack (for example puncture wounds): _____

_____

What other injuries did you suffer? _____

_____

Did an ambulance come to the scene? Yes ___ No ___ Ambulance Name:_____

Were you treated by emergency crew at the scene? Yes ___ No ___ Fire Department: _____

If so, by who: (Ambulance, EMT, Firefighter) _____

Were you transported to the hospital? Yes ___ No ___ Hospital Name:_____

Please list the names of all medical facilities you've been to since the time of the accident.

FACILITIES	FULL NAME	PHONE NUMBER/ADDRESS
Emergency department:		
Hospital		
Imaging center (X-rays, MRI etc.)		
Walk-in clinic:		
Doctor:		
Chiropractor:		
Physical therapist:		
Other:		

OTHER IMPORTANT INFORMATION

Were there any witnesses to the incident? Yes ___ No ___

If so, please list that person or persons:

Name: _____ Phone no.: _____

Name: _____ Phone no.: _____

Was Animal Control notified? Yes ___ No ___ Did they investigate? Yes ___ No ___

Were police notified? Yes ___ No ___ Did the police investigate the accident? Yes ___ No ___

Which police department/city? _____ Case #_____

Did you make any statements to anyone at the scene? Yes ___ No ___

To whom: _____

What did you say? _____

_____

_____

Did anyone make any statements to you at the scene? Yes ___ No ___

Who made the statements? _____

What did they say? _____

_____

_____

Is there any court action pending concerning this incident? Yes ___ No ___

Do you have **HEALTH INSURANCE***? Yes ___ No ___

Name of Insurance Company: _____

Insurer contact: _____ Phone no.: _____

Group/policy no.: _____ Member no.: _____

Does **MEDICARE*** pay any of your medical bills? Yes ___ No ___

Does **MEDICAID*** pay any of your medical bills? Yes ___ No ___

If yes, what is your Medicare/Medicaid no.: _____

Are you eligible to receive treatment at a VA hospital? Yes ____ No ____

Do you receive Social Security? Yes ___ No ___ If yes: SSD ___ SSI ___

Please provide a copy of ALL Health Insurance Cards- including your Medicare/Medicaid card.

INFORMATION ABOUT YOUR WORK

Were you on the job at the time of the incident? Yes ___ No ___

Has this incident affected your ability to do your job? Yes ___ No ___

If yes, please complete the following information:

Employer's name: _____

Employer's address: _____

City: _____ State: _____ ZIP : _____ Phone: _____

What is your occupation? _____

Income at the time of the incident: $_____ per _____

Any other income (commissions, bonuses, second job etc.): $_____

Income now: $_____ per _____

As a result of this incident, have you missed any time from work? Yes ___ No ___

For how many days so far: _____ Are you working now? Yes ___ No ___

Name of the doctor who told you not to work: _____

Doctor's address: _____

City: _____ State: _____ ZIP : _____ Phone: _____

Are you receiving worker's compensation insurance? Yes ___ No ___

Are you receiving disability insurance? Yes ___ No ___

Thank you for taking your time to fill out this form. It provides us with valuable information that we need to properly take care of your case. Please be assured that **we will keep this information strictly confidential** *and will not release it to anyone outside The Law Offices of Dianne L. Sawaya, unless you tell us to or give us permission to as part of your case, or as may be required by law.*